PROGRESS REPORT FOR: Tobacco

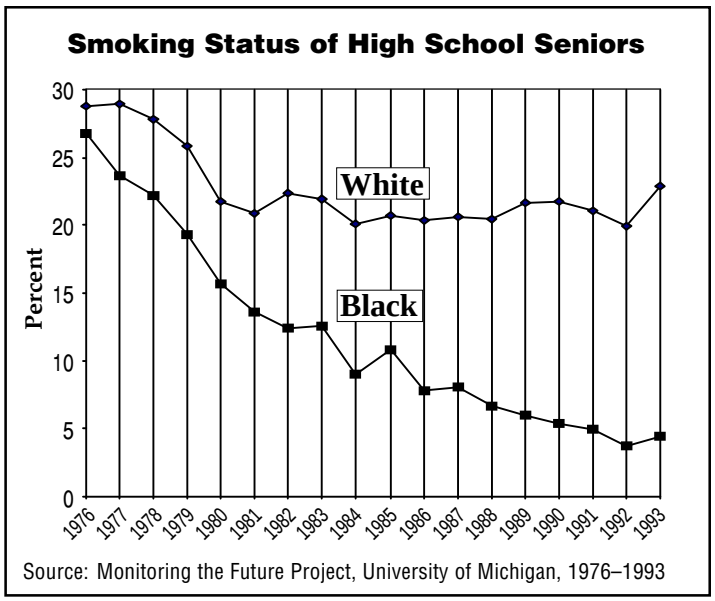
ON AUGUST 18, 1994, the Public Health Service (PHS) conducted its second HEALTHY PEOPLE 2000 review on tobacco. Opening remarks were made by the Associate Director of the Centers for Disease Control and Prevention (CDC), the Commissioner of the Food and Drug Administration (FDA), and the Director of the Center for Substance Abuse Prevention at the Substance Abuse and Mental Health Services Administration (SAMHSA). They were joined by representatives from the Connecticut Department of Health Services, American Cancer Society, Coalition on Smoking OR Health, Robert Wood Johnson Foundation (RWJ), Operation S.C.A.T., Inc. (Student Coalition Against Tobacco), Advocacy Institute, African Americans for Positive Imagery, Asian Health Services (Oakland, CA), Los Angeles Multicultural Area Health Education Center, and NW Portland Area Indian Health Board. Other Federal participants included staff from the Department of Education, Department of Labor, Environmental Protection Agency (EPA), and Federal Trade Commission (FTC). Other PHS participants included the Surgeon General and the Deputy Assistant Secretaries for Women's Health, Policy Development, and Workforce and Special Initiatives. Representatives also attended from the National Institutes of Health (NIH), Indian Health Service, and Health Resources and Services Administration.

The CDC Office on Smoking and Health Director began by reviewing the progress over the past two years to develop a comprehensive public health strategy for reducing tobacco use. Among the Federal efforts are: a proposed increase in Federal excise taxes to finance health care reform; an EPA risk assessment establishing environmental tobacco smoke as a carcinogen; an FDA review of whether nicotine is an addictive substance to be regulated under its jurisdiction; a Department of Defense smoke-free workplace policy; proposed Occupational Safety and Health Administration regulations that would require all private sector workplaces to be smoke-free; the passage of Goals 2000: Educate America Act which requires that entities receiving Federal funding for services to children prohibit smoking indoors; and several States' suits to recover tobacco-related Medicaid costs from the tobacco industry.

Smoking prevalence has declined from a 1987 baseline of 29 percent for people age 20 and older to 27 percent in 1992 (objective 3.4). However, the reduction may not be sufficient to reach the year 2000 target of 15 percent. CDC projects that, if current trends continue, 20 percent of the population will be smoking by the year 2000. American Indians/Alaska Natives have the highest smoking prevalence rates of any population group with 40 percent who smoked in 1992.

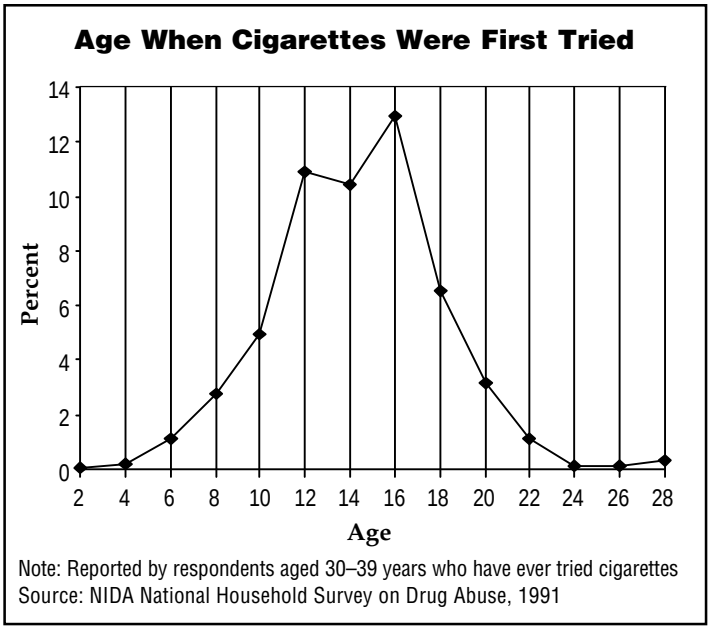
The decline in smoking has been greatest for black high school seniors. For the age group 18 to 24 years, blacks smoke less than whites. The differences in smoking prevalence between black and white teenagers cannot be explained by underreporting of smoking by blacks, high school dropouts, substitution of other drugs, later smoking initiation, parental education, school performance, personal income, or geographic region. The variance may be explained by the "lower functional value" of tobacco for blacks than for whites. For white youth, tobacco use is perceived to be "cool," whereas the social acceptability among blacks appears to be lower. Other factors may be the importance of athletics and religion among blacks, as well as the perception among whites about the potential weight-controlling effects of cigarettes.

Objective 3.5 seeks to reduce the initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular smokers by age 20. Little progress is being made; in 1992, 28 percent of people ages 20 to 24 smoked regularly, compared to 30 percent in 1987. Studies have shown that if students do not take up tobacco in high school, they are not likely to become smokers as adults.



Source: Monitoring the Future Project, University of Michigan, 1976–1993

As for cessation attempts (objective 3.6), more blacks age 18 and older stop smoking cigarettes for at least one day compared with whites. However, more whites than blacks maintain abstinence for at least one month. Objective 3.7 seeks to increase smoking cessation among pregnant women to at least 60 percent. Data indicate that smoking cessation during pregnancy is moving in the wrong direction: 39 percent in 1985, compared to 31 percent in 1991. For pregnant women with less than a high school education, the 1985 baseline was 28 percent for white women, and the 1991 rate was 21 percent for pregnant women of all races. Smoking is known to be the greatest cause of low



Note: Reported by respondents aged 30–39 years who have ever tried cigarettes
Source: NIDA National Household Survey on Drug Abuse, 1991

birthweight. However, data for objective 3.16 show that only 49 percent of obstetrician-gynecologists (OB/GYNs) inquire routinely (of 81–100 percent of their patients) about tobacco use and only 28 percent discuss strategies to quit. Even among nurse practitioners, only 51 percent inquired routinely and 20 percent discussed quitting.

Studies have also shown that 70 percent of women smokers who had quit resume smoking after delivery, thereby exposing their infants to second-hand smoke. Objective 3.8 seeks to reduce the proportion of children age 6 and younger who are regularly exposed to tobacco smoke at home to no more than 20 percent. Regular exposure is defined as smoking anywhere in the home on more than 3 days a week. Using this definition, 32 percent of children were exposed to tobacco smoke at home in 1991, down from the 1986 baseline of 39 percent.

Reducing smokeless tobacco use to no more than 4 percent of males 12 to 24 is objective 3.9. Progress is shown for males 12 to 17; 6.6 percent used smokeless tobacco in 1988, compared to 4.8 percent in 1992. For males 18 to 24, 8.9 percent used smokeless tobacco in 1987, compared to 8.2 percent in 1992. Anecdotal evidence suggests that many males give up cigarettes in favor of smokeless tobacco. The health effects of smokeless tobacco need further research.

Objective 3.10 seeks to establish tobacco-free environments in all schools. With the passage of the Goals 2000: Educate America Act, this Healthy People 2000 objective is now enacted into law. A 1992 survey found that 59 percent of worksites with 50 or more employees had smoking policies (objective 3.11). As for clean indoor air laws in all 50 States (objective 3.12), in 1994, 41 States and the District of Columbia had laws restricting smoking in public places, whereas only 18 States and D.C. had laws regulating smoking in private and public workplaces. All 50 States, the territories, and D.C. have laws prohibiting the sale and distribution of tobacco products to youth younger than age 18. Under a final rule that implements the minors' access provisions of the block grant for the prevention and treatment of substance abuse, the Synar Amendment, States will be required to enforce these laws through random unannounced inspections.

Tobacco control plans, which include comprehensive planning, evaluation, funding, and community involvement, have been adopted in 41 States and D.C. PHS funds 17 States with NIH/National Cancer Institute (NCI) ASSIST funds—$113 million over 8 years, which is enhanced with a 15 percent match by the American Cancer Society in 17 States and in 33 States with CDC IMPACT dollars. In addition, RWJ has provided $10 million to support State tobacco control activities in 19 States.

A summary of follow-up items includes the need to develop key elements of the PHS strategic plan to focus on youth. Improve partnerships among Federal, State, and local government entities involved in tobacco control to prevent tobacco initiation and use by youth. Summarize PHS activities that help reduce the "functional value" of tobacco for youth, by increasing partnerships with community-based groups, such as the YWCA, YMCA, Girl Scouts, and Boy Scouts of America. Develop a plan to strengthen counteradvertising against tobacco use. Engage the FTC in addressing tobacco advertising issues. Indicate how the efforts of PHS, specifically CDC and NCI, will be coordinated with RWJ, EPA, and the Departments of Education and Agriculture. Summarize how tax policies among reservations might affect smoking prevalence differences among American Indians/Alaska Natives. Establish an agenda for working with tribal groups to introduce pricing policies more directly in the tobacco control strategies. Indicate how the Association of State and Territorial Health Officials can be involved with the National Association of State Alcohol and Drug Abuse Directors in the implementation of the Synar amendment. Develop a strategy for working with OB/GYNs and nurse practitioners to discourage tobacco use during pregnancy and to encourage new mothers to maintain smoke-free homes. Apprise interested parties of FDA's initiatives on tobacco. Summarize research strategies related to the health effects of smokeless tobacco. Summarize the legislative initiatives on tobacco that should be considered for the next Congress.

Public Health Service Agencies

Agency for Health Care Policy and Research
Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health
Substance Abuse and Mental Health Services Administration
Office of the Surgeon General

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